STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, prim ppic	00	COMPLETED
		15E187	A. BUILDING B. WING		05/25/2011
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R		PADDRESS, CITT, STATE, ZII CODE	
SIMMON	IS LOVING CARE H	HEALTH FACILITY	I	IN46407	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or the Investigation of	F0000	June 14, 2011	
		_	1 0000		
	Complaints IN00090539 and IN00090585.				
				Ms. Kim Rhoades, R.N.	
	Complaint IN00	090539 - Substantiated.		Director	
	Federal/State de	ficiencies related to the		Indiana State Department of H	ealth
	allegations are c	ited at F272, F314, and		2 North Meridian Street	
	F323.			Indianapolis, IN 46204	
	r 525.				
	G 1: DI00000505 G 1 4 4 4 4 1			Plan of Correction	
		090585 - Substantiated.		D 14 DI 1	
		ficiencies related to the		Dear Ms. Rhoades,	
	allegations are c	ited at F272, F314, and		Lanca lancivina CMS 2567 al	
	F323.			I am submitting CMS-2567 pla correction as a credible allegat	• • • • • • • • • • • • • • • • • • •
				compliance to the May 25, 201	
	Survey dates: M	May 24 and 25, 2011		health survey. All corrections	
	Survey dates. Iv.	1ay 24 and 23, 2011		completed by June 24, 2011.	WIII DE
	D 11:	000260		completed by same 21, 2011.	
	Facility number:			The Q.A. Committee will meet	t l
	Provider number			monthly to ensure all deficient	• • • • • • • • • • • • • • • • • • •
	AIM number: 1	00275220		practices of the facility have be	• • • • • • • • • • • • • • • • • • •
				corrected. After all deficiencie	es are
	Survey team: Ja	nelyn Kulik, RN		recognized as being corrected l	by the
	, , , , , , , , , , , , , , , , , , , ,			State Board of Health Q.A. me	·
	Congue had tuna			will resume meeting quarterly	• • • • • • • • • • • • • • • • • • •
	Census bed type	•		will reserve the right to meet n	
	NF: 22			frequently depending upon the	needs
	Total: 22			of the facility.	
				We are still be in a suit.	.:41. 41
	Census payor ty	pe:		We are still having problems w	I
	Medicaid: 21			transition to the MDS 3.0 system The company is still trying to v	• • • • • • • • • • • • • • • • • • •
	Other: 1 Total: 22			out the problems in this new sy	• • • • • • • • • • • • • • • • • • •
				which is causing a great delay	
	10101. 22			response time for customer sup	• • • • • • • • • • • • • • • • • • •
				response time for eustomer sup	,port.
	Sample: 6				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATH COME 05/25/	PLETED
	PROVIDER OR SUPPLIER		STREET A 700 E 2	ADDRESS, CITY, STATE, ZII 21ST AVE IN46407	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE ()	(X5) COMPLETION DATE
TAG	These deficiencies findings cited in 16.2.	es also reflect State accordance with 410 IAC ompleted 6/2/11 by	TAG	I am sorry I am subr fax and mail but I co the computer system report. Please contact me if questions. Sincerely, Mrs. Herberta B. Mi Administrator	nitting this via ould not log in on a to send the you have any	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		STRUCTION 00	(X3) DATE S COMPL			
		15E187	B. WING	u		05/25/2	011
	ROVIDER OR SUPPLIER S LOVING CARE H		ST 70	00 E 21	DDRESS, CITY, STATE, ZIP CODE ST AVE 146407		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
F0272 SS=D	periodically a com standardized repro- each resident's fur A facility must mak assessment of a re RAI specified by th	te a comprehensive esident's needs, using the needs. The assessment					
	must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;						
Special Dischar Docum regard perfor protocol Docum Base intermasses for 1 samp	Discharge potential Documentation of regarding the additional performed through protocols; and Documentation of	ge potential; entation of summary information ng the additional assessment ed through the resident assessment					
	interview, the assess a reside for 1 of 1 reside	he facility failed to ident for risks of falling esident who fell in a (Resident #E) and	F0272	2	F Tag 272 Resident Comprehensive Assessmen What corrective action will be accomplished for those resid found to have been affected if the deficient practice? Resid 1 fall assessment was comple	ents by dent eted	06/24/2011
	accurately assess the risk for pressure sores and assess pressure sores for 1 of 2 residents reviewed			immediately and nurse admis record updated with fall risk assessment. Resident D rec was reviewed and the Brader Scale Assessment was discu	cord n		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15E187	B. WIN	IG		05/25/2	011
NAME OF	PROVIDER OR SUPPLIEI	·	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	I KOVIDEK OK SOI I EIEI			700 E 2	1ST AVE		
	IS LOVING CARE I			L	IN46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
	with pressure	sores in a sample of 6			with all licensed nursing staf was noted that the Braden S		
	(Resident #D)				Assessment was not accura		
				and should have indicated a			
		1			higher risk for development		
	Findings include:				pressure areas since she ha		
					been a prior resident with		
	1. The record	for Resident #D was			pressure areas. MDS was		
		/25/11 at 8:37 a.m.			reviewed with emphasis on		
					wound documentation. The wound assessment sheet wa	20	
	The resident's	diagnoses included,			also reviewed and emphasis	_	
	but were not 1	imited to, Alzheimer's			on always placing one woun	-	
	disease, seizure disorder, dementia,				area on one sheet because i		
	1				easier to track the healing		
	"	arthritis, depression,			process and course of treatn		
	cerebrovascul	ar accident (stroke),			Resident D record is a close		
	chronic obstru	ctive pulmonary			record therefore we only rev		
		D), and congestive			it as a learning tool. 2. Hov other residents having the	V	
	`	b), and congestive			potential to be affected by th	e	
	heart failure.				same deficient practice will be		
					identified and what corrective		
	A Braden Sca	le Assessment (scale			action will be taken. All med	dical	
		`			records of residents fall		
		for pressure sores)			assessments were audited a	ind	
	was complete	d as follows: on			no other resident was found deficient. No other resident	was	
	3/11/11 with a	score of 17 which			affected. Medical records of	vvas	
	indicated low	risk for pressure			residents with Pressure Area	s will	
		•			be assessed and documente		
	1	7/11 with a score of			accordingly. All residents Br	aden	
	16 which indi	cated a low risk for			Scales were reviewed for		
	pressure sores	; on 3/27/11 with a			accuracy and no other reside		
	1 *	nich indicated a low			was affected. 3. What meas will be put into place or what		
					systemic changes will be ma		
	_	are sores; on $4/3/11$			ensure that the deficient prac		
	with a score o	f 14 which indicated a			does not recur. In Service or		
	moderate risk	for pressure sores;			documentation for residents	Fall	
		1 with a score of 13			Assessments on accuracy a	nd	
	and 011 4/14/1	i willi a score of 13			completion was done. In		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLE		
ANDILAN	or connection	15E187	A. BUI		00	05/25/20	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	3			1ST AVE		
SIMMON	IS LOVING CARE I	HEALTH FACILITY		GARY, I			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION DATE
IAU		ed a moderate risk for		IAG	Service on Braden Scale and		DAIL
						٠ ١	
	The Annual Massessment (Massessment (Massess	dinimum Data Set MDS), dated 3/11/11, resident sometimes and was sometimes she was severely attively indicated she was a limited assist and bed mobility she was highly e activity and with a sist. She was ontinent of bowel and had problems with her at term memory. The not at risk for essure sores and had no			Plan of Care was reviewed a with the proper completion of MDS according to skin and pressure areas. The weekly wound assessment was also reviewed. Documentation proof Fall Assessment, Braden Scale, MDS, and Weekly Wound assessment will be review at provided to nurses. 4. How corrective action will be mon to ensure the deficient practic will not recur. D.O.N. designed will monitor all admission nuradmission records and fall risk assessments upon admission and quarterly fall risk assessments. How the correcur. A R.N. will be assigned audit and monitor documentation of residents with Pressure Ar Braden Scale, Braden Scale of Care and MDS upon admission, significant change quarterly. The Weekly Wourn Assessment will be monitored weekly and reviewed with worn nurse monthly. Director of Nursing and or designee will and monitor monthly and determine future in-service training needs. The D.O.N. discuss progress and concert the Q.A. Committee and the committee will determine effectiveness of the following effectivene	oblicy bund ind the ditored ce ee esk n ctive eation reas, Plan e and ed bund audit will rns to	
		of old healed decub			policy and procedures: Fall	'	
	(decubitus) to	r (right) hip			Assessment, Braden Scale, Braden Scale Plan of Care,		

l í		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 05/25/2011
		15E187	B. WIN			05/25/2011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
SIMMON	IS LOVING CARE H	IENI TH ENCILITY		1	21ST AVE IN46407	
			_		111111111111111111111111111111111111111	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	surrounding ti	issue WNL (within			Weekly Wound Assessment	. 5.
	_	." Scab measured 1			Completion Date: 6/24/2011	
	cm (centimeter) by 0.7 cm by 0 cm.				ADDENDUM The corrective action taken for resident E w	
	· ·	was informed, and an			fall assessment was comple	ted
		ived for zinc oxide to			and a lap buddy is applied w	
					up in wheelchair to prevent he from leaning to far foward. N	
		ice a day and as need			other falls have occured with	
	until resolved.	Family notified.			Resident E. The corrective a	
					for resident with pressure ar was having each pressure a	
	A nursing note	e, dated 3/20/11 at			noted on one page to track t	
	7:00 p.m., indi	00 p.m., indicated an open area			progess or decline of the	
	was noted to ri	1			wound. The wound nurse	.
					monitors the wound monthly prn and the physician will mo	
	_	m by 0.7 cm by 0 cm.			the wound monthly and prn.	
	1 .	was informed and an			corrective action taken for	
		ue zinc oxide to			residents having the potential be affected by falls is as follows:	
	buttocks was r	eceived. The family			Fall Risk Assessment is	JWS.
	was informed.				completed upon admission	
					and updated quarterly and a	
	A nursing note	e, dated 3/28/11 at			needed. If a resident falls a fall assessment is done to	post
	l	cated, "blister to			determine any risk factors	
		d." At 3:45 p.m., the			causing the residet to fall. If	a
	~	in to see the resident.			resident is at risk for falling Physical Therapy will be	
	1 ^	shoes were too big.			consulted to determine what	
		<u>-</u>			anti-falling devices are need	1
	· ·	s made aware and			such as lap buddy, alarm se low bed, bolsters and or	11501,
	iamily was to	bring in new shoes.			wedges. The corrective action	
					taken for residents having th	1
	A nursing note	e, dated 4/7/11 at 2:00			potential for pressure areas follows: Braden Scale is do	
	p.m., indicated	l, "blister to r (right)			determine residents who are	
	heel remains, s	skin hard, dry, et			risk and pressure relieving	
	(and) dark in c				devices are used. The wour monitored and if the area	nd is
					monitored and it the area	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15E187	B. WIN			05/25/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			1ST AVE		
SIMMON	IS LOVING CARE H	HEALTH FACILITY		1	N46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	<u> </u>	a d 4 a	DATE
	drainage noted	d."			worsens the resident is refer the wound clinic and plan of		
					is determined and followed.		
	A nursing note	e, dated 4/13/11 at			resident will continue to follo		
	1				with the wound clinic until wo		
	1	icated, "resident			is healed.The systemic meas		
	appears to be	sleeping. Eyes open			put into place are all residen		
	when name ca	ılled. Responds			are a high fall risk are monito each shift for anti-falling devi		
	verbally." The	e resident was			This is dicussed during shift		
	1 -	nargic. At 5:15 a.m.			shift report and tour check.	The	
		ng care the resident			resident is monitored through		
		•			each shift 24 hours per day.		
was more lethargic. An order was				shift is monitored by the char nurse and any falls or incider			
	received to sent to ER for				are reported to the D.O.N.	11.5	
	evaluation and	d treatment. Family			immediately. The D.O.N. wil	I	
	notified.	,			monitor the fall risk assessm		
	nouncu.				and anti fall devices weekly t		
					1 month then monthly for six months to ensure ongoing		
		sfer sheet dated			compliance. The systemic		
	4/13/11, indicate	ated 5:00 a.m.,			measures put into place are		
	"Resident app	ears to be sleep (sic).			residents had an updated Br Scale and Plan of Care	aden	
	Open eyes wh	en name called.			completed. Residents with h	niah	
	Verbally respo	onsive. But very			risk of pressure sore	5	
	1 -	s be (sic) getting more			developement is discussed of	during	
	_	ox (sic) x (times) 5			shift to shift report and tour check. The resident is monit	tored	
	• • • •	nt has almost healed			each shift for pressure reliev	ing	
					devices such as heel protect		
	1	or (right) buttock and			air mattress, gel cushions an to bed to releive pressure, th		
	hip. Healing l	blister to r (right)			are turned and repositioned	•	
	heel."				2 hours and as needed. The	-	
					resident is assessed each		
	Δ nurging not	e, dated 4/14/11 at			shift and if a pressure area is		
	ı	•			noted the physician is contact to determine the course of	ctea	
	1 *	icated the resident			treatment. The Licensed Nu	rse	
	returned to the	e facility. "R (right)			will monitor skin sheets weel		
	<u> </u>					,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 05/25/2	LETED	
	PROVIDER OR SUPPLIER		p . waw	700 E 2	ADDRESS, CITY, STATE, ZIP CODE 1ST AVE IN46407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	noted, dry, har The areas mea cm by 0 cm ar 0 cm. "Reope hip measured cm." A new of apply santyl (value) and arginaid (resupplement) of At 7:00 p.m., renotified of the A nursing noted to the result of the A nursing noted to the result of the renoted to the result amount drainage noted in bed. A dresult orders and the orders and the orders and the renoted to the result of the re	ne box twice a day. the wound nurse was			and for residents with pre areas the wound is monit daily. The D.O.N. will mo weekly wound sheets we monitor progress or regre pressure areas weekly or until pressure area is reso	ored nitor ekly and ssion of going	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		A. BUI	LDING	NSTRUCTION 00	COM	TE SURVEY SPLETED 5/2011	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP 1ST AVE N46407	_	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	wound continuorder was received to sta 500 mg (millig four times a da Propass (nutrit mix with wate with normal sa duoderm (dres days. The fam. A nursing note 6:00 a.m., indichange to r (rig smelling drain	led to drain. An ived to go to wound as possible. At 2:00 king rounds, the oted to have an open cyx with a small eding noted. The area in by 1 cm by 0.2 cm. odor. The physician and an order was int Keflex (antibiotic) grams) one by mouth my for 14 days and cional supplement) in daily, Clean wound aline and cover with sing) every three filly was notified.			(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	
	remains dark a a.m., the reside wound clinic f areas to right h	and hard. At 8:00 ent was to go to the for evaluation of open hip, right heel, and family was notified.					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THETETAL	or correction	15E187	A. BUI B. WIN	LDING		05/25/2011
NAME OF I	DROLUDER OR CURRULER		D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER			1	1ST AVE	
	IS LOVING CARE H			GARY,	IN46407	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	At 12:30 p.m.,	the resident was out				
	to wound clinic and staff					
	accompanied.					
	_					
	A Wound Clin	ic Note, dated				
	4/26/11, indica	ated the resident had				
	a temperature	of 100.5 degrees.				
	The right hip v	wound measured 3.0				
	cm by 2.4 cm	by 1.2 cm, the				
	granulation tex	kture was pale/gray,				
	and there was	a moderate amount of				
	purulent exuda	ate with odor. The				
	periwound app	pearance was				
	erythema (red)	and the necrosis was				
	present. The r	ight heel wound				
	measured 9.0 o	em by 3.5 cm by 0.1				
	cm. The area	was necrotic with no				
	drainage. It w	as dry gangrene. The				
	coccyx area m	easured 1.0 cm by 0.9				
	cm by 0.1 cm.	The periwound area				
	was intact. Th	ere was no drainage				
	or odor.					
	A hospital His	tory and Physical,				
	dated 4/26/11,					
	resident was tr	ansferred with fever				
	· ·	on. The impression				
		r disease, history of				
	past strokes, d	ecubitus right hip,				

PRINTED: 06/23/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E187	A. BUILDING	00	COMPLETED 05/25/2011
		130107	B. WING	LANDARIO CITAL CONTROL	05/25/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 21ST AVE	
SIMMON	S LOVING CARE H	IEALTH FACILITY		IN46407	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION DATE
		ation, and necrosis of			
		e plan: "The patient			
	will be started	on IV (intravenous)			
	antibiotics. Su	ibsequently,			
	debridement a	nd possible g-tube.			
	Will have Infe	ctious Disease			
	consult with th	ne primary			
	physician."				
	A Weekly Wou	and Assessment Flow			
	Record indicat	ted 3/17/11 wound			
	identified with	the box marked yes.			
	The location w	vas the right buttock,			
	staged indicate	ed excoriation. The			
	tissue was red.	the treatment was			
	zinc oxide and	she had an air			
	mattress and g	el cushion as			
	pressure reliev	ring devices. On			
	$\frac{1}{3/27/11}$ the for	rm indicated the area			
	was healed.				
	A Weekly Wou	and Assessment Flow			
	Record indicat	ted 3/17/11 the box			
	was checked for	or yes that a wound			
	was identified.	The location			
	indicated right	buttock and the the			
	stage was un-s	tageable (scab).			
	_	assessment noted of			
	the tissue colo				

000368

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15E187	B. WIN			05/25/2	011
NAME OF I	PROVIDER OR SUPPLIEI	.	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	1ST AVE		
SIMMON	IS LOVING CARE I	HEALTH FACILITY		GARY, I	N46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		was documented.	+	IAG	·		DATE
		drainage or odor.					
		lges were in normal					
		surrounding tissue					
		The treatment was					
		d an air mattress and					
		ere used for pressure					
	•	ces. On 3/27/11 the					
	1	d a check mark by the					
		ied. The location was					
		and the stage healing.					
	_	or was cab off solid					
		The area measured 2					
	1 -	y 0 cm. There was no					
		lor. The wound edges					
	_						
		ormal limits and the					
	_	ssue was within					
	normal limits.						
	_	e treatment was was					
		d pressure relieving					
		led an air mattress and					
	gel cushion. (On 3/28/11 there was					
	a check in the	box yes there was a					
	wound identif	ied. It was staged as					
	a blister and the	he tissue color was					
	fluid filled. th	nere were no					
	measurements	s indicated. There was					
	no drainage a	nd on odor. The					
	_	were attached and the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE COMPL	ETED	
	IDER OR SUPPLIER OVING CARE H	EALTH FACILITY		700 E 2	ADDRESS, CITY, STATE, ZIP CODE 11ST AVE IN46407	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
sur The and relation of the state of the sta	rrounding tishe treatment d an air matter lieving device box marked wound was instageable as ptured. There is easurements mount of drain color, the end the surroundithin normal as zinc oxided d heel protect lieving device attress and house sessment Flight hip in the end skin treatment of the resident weekly Wound the resident weekly we wound was in the resident weekly we wound the resident weekly we would be resident weekly we would we would be resident we we would be resident we were well as a subject we would be resident w	ssue was normal. of heel protectors tress was the pressure te used. On 4/3/11 d yes was check for dentified. it was nd the blister had re was nothing ssue color or . There was a small mage that was serous dges were attached nding tissue was limits. The treatment e, dressing and tape ectors. The pressure tes were low air eel protectors. other Weekly Wound ow Record for the e resident's chart or in tent book until o other flow records t's right heel. and Assessment Flow 4/14/11 indicated a teed in the box that a		TAG			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		(X2) MUI A. BUILE B. WING		NSTRUCTION 00		(3) DATE (COMPL 05/25/2	ETED	
	PROVIDER OR SUPPLIER				DDRESS, CITY, STAT 1ST AVE N46407	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)		(X5) COMPLETION DATE
	wound was ide	entified to the right	İ					
	hip the tissue	color was spongy and						
	the area measu	ared 1 cm by 1 cm by						
	undetermined.	There was a small						
	amount of sero	osanguinous drainage						
	(contains seru	m and blood) with no						
	odor. The edg	ges were attached and						
	the surroundin	g tissue was normal.						
	On 4/19/11 the	e right hip measured 1						
	cm by 1 cm by	undetermined. The						
	tissue was spo	ngy with						
	serosanguinou	s drainage and no						
	odor. The trea	atment was changed						
	to santyl cover	r with hydrogel and						
	foam dressing	twice a day. On						
	4/25/11 the rig	ght hip was pale red						
	and measured	2.5 by 2 cm by						
	undetermined.	There was a small						
	amount of sero	osanguinous drainage						
	that had an od	or and the wound was						
	deteriorating.	On 4/25/11 a wound						
	had been ident	tified to the coccyx						
	area that was a	a Stage II. The area						
		measuring 1 cm by 1						
	-	there was a small						
	-	ous (serum) drainage						
	with no odor.	. , , ,						
	A Weekly Wo	und Assessment Flow						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	KF0Z11	Facility II	D: 000368	If continuation she	et Pa	ge 14 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187			LDING	NSTRUCTION 00		X3) DATE S COMPLI 05/25/2 (ETED	
NAME OF I	PROVIDER OR SUPPLIEI	!!			DDRESS, CITY, STA	TE, ZIP CODE		
					1ST AVE			
	IS LOVING CARE I			GARY, II	N46407			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE	ED TO THE APPROPRIATE ICIENCY)		DATE
	Record dated	3/20/11, indicated a						
	check was pla	ced in the box yes for						
	wound identif	ied to right buttock at						
	a Stage II. Th	e tissue was red and						
	the area meas	ured 1 cm by 0.7 cm						
	by 0 cm. ther	e was no drainage or						
	odor. The edg	ges were attached and						
	the surroundir	ng tissue was normal.						
	The treatment	was continue zinc						
	oxide and the	pressure relieving						
	devices were	air mattress and gel						
	cushion. On 3	3/27/11 the right						
	buttock area v	vas a Stage II red in						
	color, measur	ing 1 cm by 0.7 cm by						
	0 cm with no	drainage or odor. The						
	wound edges	were attached and the						
	surrounding ti	ssue was normal.						
	The treatment	and pressure						
	relieving devi	ces were the same.						
	· ·	e Right buttock was a						
		color measuring 1						
		by O cm. There was						
	1 *	o odor, the wound						
		tached and the						
	_	ssue was normal.						
	The treatment							
		ces were not changed.						
	·	e right buttock was a						
		ring 0.7 cm by 0.3 cm						
FORM CMS-2	2567(02-99) Previous Versi		 KF0Z11	Facility II	D: 000368	If continuation she	eet Pac	ne 15 of 43

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	(X2) MUI A. BUILE B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/25/2	LETED
	PROVIDER OR SUPPLIER		F	STREET A	DDRESS, CITY, STATE, ZIP CODE 1ST AVE N46407	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	by 0 cm. The growth with not the edges were surrounding tist. There was no extreatment or the devices. There were not Assessment Flaight buttock. The Weekly Proor Skin Tear M Schedule Police the Director of at 1:15 p.m. The ensure the resident is to the oppossible with separate to the opposite to th	tissue had epithelial of drainage or odor. The attached and the saue was normal. The change in the see pressure relieving other Weekly Wound ow Records for the sesure Area, Blister Heasurement by was provided by F. Nursing on 5/25/11 The purpose: "To dent's skin condition timal level as skin becoming intact. "Braden Scale" on admission, orly there after and int change. 2. If intified at risk for			CROSS-REFERENCED TO THE APPROPR		
	precautions/in	tin integrity provide terventions to sk of pressure areas,					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			<u> </u>		INSTRUCTION 00	(X3) DATE S COMPL	
		15E187	A. BUI B. WIN			05/25/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	1	
SIMMON	IS LOVING CARE H	IFALTH FACILITY		1	11ST AVE IN46407		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID I	1111-0-107		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	UE.	DATE
	1	tear. 3. Document					
		ems, interventions					
		esident's care plan. 4.					
	_	odate the care plan					
	with scheduled	d revisions of					
	resident's cond	lition changes. 5. If					
	_	blister or skin tear					
	1	and document the					
	1 -	l assessment: A.					
	Location. B. S	Stage etc. C. size					
	(cm) length x ((times) width. D.					
	wound depth (cm). E. Odor. F.					
	Drainage. G.	Admitted with					
	pressure area of	or facility acquired.					
	H. Physician n	otified and treatment					
	order. I. Fam	ily notification. All					
	-	nd areas with eschar					
	tissue will be r	referred to the Wound					
	Nurse or Wour	nd Clinic. 2. Weekly					
	measurements	will be recorded on					
	the weekly wo	ound assessment					
	sheet. 3. Pres	sure Area Long Sheet					
	will be comple	eted monthly and					
	given to the Di	irector of nursing for					
	Quality Assura	ance Meeting."					
	On 5/25/11 at	1:00 n m the					
	On 5/25/11 at	_					
		rsing (DoN) was She indicated that the					
	miterviewed.	mulcated that the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187			LDING	NSTRUCTION 00	(X3) DATE COMPI 05/25/2	ETED	
	PROVIDER OR SUPPLIEF		1	700 E 2	DDRESS, CITY, STATE, ZIP CODE 1ST AVE N46407		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	above Weekly Flow Record right buttock as should not have buttock but right indicated there. Weekly Woun Record missing and right heel. DoN indicated two areas to the 3/17/11 area thand the open as the right button further indicated into where the Assessment Figure 1 are wound Assess were requested DoN. The Dot the missing Wassessment Figure 1 are worth as the provide the formula of the provide the formula of the missing Wassessment Figure 2 are well as the provide the formula of the provide the provide the formula of the provide the provide the formula of the provide t	Wound Assessment that included the and the right heel we indicated right ght hip. She further the must be a sheet of a disconsistent of the right hip. At this time the she hat there had been the right buttock: the mat healed on 3/27/11, the area that was found on the cks on 3/20/11. She the she would look to Weekly Wound how Records were and the right would have the work were and the she would look to the work were and the she would look the weekly wound how Records were and the she would look the weekly wound how Records were and the she would look the weekly wound how Records were and the she would look the weekly wound how Records were and the she would look the weekly would look the weekly wound have the work were and the work would look the weekly would l		TAG		NICE TO THE PROPERTY OF THE PR	DATE
	On 5/25/11 at	3:15 p.m. the DoN					

000368

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187			ULTIPLE CON LDING IG	OO		COMPLET 05/25/201	TED	
			D. WIN		DDRESS, CITY, STA	TE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	K		700 E 21				
SIMMON	IS LOVING CARE I	HEALTH FACILITY		GARY, IN	N46407			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIATE CIENCY)	·	COMPLETION DATE
		ed. She indicated that						
		dent returned to the						
		4/11 the resident's hip						
	· ·	ongy and the scab						
	_	present and there						
	· ·	n like membrane						
		b had been located.						
		ere was something						
		membrane." We						
	were not goin	g to break the						
	_	t the treatment was						
	changed to sa	ntyl in hopes of						
		The wound nurse						
		9/11 and changed the						
		n, then overnight on						
		ound changed and an						
		eived to go to the						
		The soonest we						
		in was the next day.						
		she requested the						
	_	e Director/Human						
	Resource Mar	nager to get the QA						
		ance papers). The						
	` *	d these forms would						
	have the wour	nd measurement that						
		ested earlier in the						
	1	cated this would be						
	1	ident's record because						
	_	ies of the Weekly						
FORM CMS-2	2567(02-99) Previous Versi	· · · · · · · · · · · · · · · · · · ·	 KF0Z11	Facility II	D: 000368	If continuation she	et Page	19 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		15E187	A. BUI B. WIN	LDING IG		05/25/2	011
NAME OF I	PROVIDER OR SUPPLIE	R	!		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SIMMON	IS LOVING CARE I	JENITH ENCHITY		1	11ST AVE		
					IN46407		QUE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE .	DATE
	Wound Assess	sment Flow Record.					
	The copies we	ere provided. The					
	DoN then ind	icated that the Weekly					
	Wound Assess	sment Flow Records					
	were different	from the forms					
	previously pro	ovided, because she					
	told staff that	all information on					
	one skin area	was to be on one					
	form. She did	l not want different					
	wound areas of	on the same form.					
	There was add	ditional data provided					
	on these form	s that was not on the					
	original forms	s that had been					
	provided. At	this time she also					
	indicated the j	physician had seen the					
	resident's wou	ands on 3/30/11 but					
	had not been l	back in to the facility					
	due to persona	al reasons but the					
	facility had th	e wound nurse come					
	in and see the	resident.					
	2. The record	for Resident #E was					
	reviewed on 5	5/24/11 at 11:45 a.m.					
	The resident v	vas admitted to the					
	1 *	/11. Her diagnoses					
	1	were not limited to,					
	diabetes melli	tus, coronary artery					
	disease, hyper	tension, left above					
	the knee ampu	utation, and right					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E187			A. BUII	LDING	NSTRUCTION 00	(X3) DATE SU COMPLET 05/25/201	ED
		1JE 107	B. WIN		DDDECC CITY CTATE ZID CODE	03/23/20	1
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
	S LOVING CARE H	EALTH FACILITY		1	IN46407		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (DATE
	below the knee	e amputation.					
	dated 4/4/11 at the section "Hi not completed boxes checked areas: "if chec evaluation requ policy," "no hi in past 30 days." A nursing note 6:49 a.m., indi	uired per facility story of falls," "fell s," and "fell in past e, dated 4/30/11 at cated resident					
	via wheelchair	ner and propelled self to room along with					
	*	ident was found on					
		or, crying. Staff esident for bruising,					
		vas noted to right					
	forefinger.	rus notou to right					
	-31411110411						
	Interview with	Social Service					
	Director/Huma	an Resource Manager					
	on 5/25/11 at 8	3:25 a.m., indicated					
	all area of the	Resident Nursing					
	Assessment fo	rm need to be					
	completed. No	o area should be					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT (X2) MULTIPLE CONSTRUCT (X3) MULTIPLE CONSTRUCT (X4) MULTIPLE CONSTRUCT (X4) MULTIPLE CONSTRUCT (X5) MULTIPLE CONSTRUCT (X6) MULTIPLE (X				00 COMPLETED 05/25/2011		
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP (21ST AVE IN46407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	blank. Interview with at 8:35 a.m., in the Resident N form were to be resident was a facility. No an Interview with Nursing on 5/2 indicated the at #E's resident of form was blanchave been, how been another form pleted. The computer programs assessment concentrated the exist computer. At the exist contact at 4:00 p.m. the indicated there assessment concentrates.	LPN #1 on 5/25/11 Indicated all areas of dursing Assessment be completed when a dmitted to the rea should be blank. In the Director of 25/11 at 3:15 p.m., area on the Resident hoursing assessment is and it should not ever there may have fall assessment the facility had new grams and the facility had new gram	1	CROSS-REFERENCED TO THE		
	This federal ta	g relates to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/25/2011	
	PROVIDER OR SUPPLIER		700 E 2	ADDRESS, CITY, STATE, ZIP CODE 21ST AVE IN46407	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Complaints IN IN00090585. 3.1-31(c)(2)	100090539 and			
F0314 SS=G	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having precessary treatments from develoting prevent in sores from develoting precessive ulcers and assess and clearly ulcers when identification facility policy for reviewed with prof 6. (Resident # practice resulted developing multipressure ulcers when identification of the practice resulted developing multipressure ulcers when identifications when identifications are some content of the practice resulted developing multipressure sores described and the practice resulted the pressure and the practice resulted and the pressure sores are sorted and the pressure and the press	review and interview, the completely and the resident's risk for and failed to accurately y document pressure tified, in accordance with r 1 of 2 residents ressure ulcers in a sample (D) The deficient	F0314	F Tag 314 Treatment/SVCS Prevent/Heal Pressure Sore What corrective action will b accomplished for those resi- found to have been affected the deficient practice? Brace Scale Assessment and Weel Wound Assessment was reviewed for resident D. Th review was for in-service tra since this was a closed reco All residents with pressure a were immediately reviewed accuracy. All residents Brace Assessments were reviewed	es 1 pe dents I by den ekly e aining ord. areas for den

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KF0Z11

Facility ID: 000368

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETED	
		15E187	B. WIN			05/25/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R		1	1ST AVE		
SIMMON	IS LOVING CARE H	HEALTH EACH ITY		1	N46407		
	O LOVING CARL I	ILALITTACILIT		<u> </u>	114-0-107		
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION SHOULD BE				(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	to a wound with	purulent drainage and			ensure accuracy. All modera		
	odor requiring h	ospitalization for care.			and high risk residents have	been	
					identified properly. It was determined that Resident D		
	Findings include	: :			status had changed and she	was	
					high risk for pressure sore	wao	
	The record for D	esident #D was reviewed			development because of		
					declining medical condition.		
		37 a.m. The resident's			Resident D was once a hosp		
	"	led, but were not limited			resident admitted with pressi		
	1 '	disease, seizure disorder,			sores and peg tube, whom w had rehabilitated and was	/e	
		tension, arthritis,			discharged off of hospice and	d	
	depression, cerel	brovascular accident			returned home. Resident de		
	(stroke), chronic obstructive pulmonary				was sudden and returning to		
	disease (COPD)	, and congestive heart			prior hospice medical status		
	failure.	,			pressure areas and need for		
	landic.				tube. We are aggressively		
	A D 1 C 1.	A			assessing the residents with		
		Assessment (scale to			declining medical conditions		
	1	ressure sores) was			How other residents having t		
	1 ^	llows: on3/11/11 with a			potential to be affected by th same deficient practice will be		
	score of 17 which	h indicated low risk for			identified and what corrective		
	pressure sores;	on 3/17/11 with a score of			action will be taken. All resi		
	16 which indicat	ted a low risk for pressure			with high and moderate risk		
	1	1 with a score of 16			pressure sore development	were	
	1	a low risk for pressure			identified and will be closely		
		with a score of 14 which			monitored and assessed. No		
	1	erate risk for pressure			other resident was affected. What measures will be put in		
		*			place or what systemic chan		
	1	14/11 with a score of 13			will be made to ensure that t		
		a moderate risk for			deficient practice does not re		
	pressure sores.				In Service on documentation		
					residents Braden Scale		
	The Annual Min	imum Data Set			Assessments on accuracy a	nd	
	Assessment, date	ed 3/11/11, indicated the			completion was done. In	_	
	1	nes understands and was			Service on Braden Scale and		
		rstood. She was severely			Plan of Care was reviewed a with the proper completion o		
		•			MDS according to skin and	1 1110	
	impaired cogniti	vely, indicating she never					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F187 05/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE or rarely made decisions. The resident pressure areas. The weekly wound assessment was also was a limited assist with transfers and bed reviewed. Documentation policy mobility, indicating she she was highly of Braden Scale, and Weekly involved in the activity and with a one Wound Assessment will be review and provided to nurses. person assist. She was frequently 4. How the corrective action will incontinent of bowel and bladder. She be monitored to ensure the had problems with her long and short term deficient practice will not recur. memory. The resident was not at risk for D.O.N. designee will monitor all developing pressure sores. There were no admission nurse admission records skin assessments and pressure sores and had no healed pressure determine risk factors for sores. development of pressure areas and quarterly thereafter unless A nursing note, dated 3/17/11 at 8:00 significant change is noted. A R.N. will be assigned to audit and p.m., indicated, "resident toileted by staff, monitor documentation of excoriation noted to r (right) buttock and residents with Pressure Areas. dark dry scab in center of old healed Braden Scale, Braden Scale Plan of Care and MDS upon decub (decubitus) to r (right) hip admission, significant change and surrounding tissue WNL (within normal quarterly. The Weekly Wound limits)." Scab measured 1 cm Assessment will be monitored (centimeter) by 0.7 cm by 0 cm. The weekly and reviewed with wound physician was informed and an order was nurse monthly. Director of Nursing and or designee will audit received for zinc oxide to excoriation and monitor monthly and twice a day and as need until resolved. determine future in-service Family notified. training needs. The D.O.N. will discuss progress and concerns to the Q.A. Committee and the A physician order, dated 3/17/11 at 8:00 committee will determine p.m., indicated apply zinc oxide to effectiveness of the following excoriation to right buttock and right hip policy and procedures: Fall three times a day and as needed until Assessment, Braden Scale, Braden Scale Plan of Care, resolved. Weekly Wound Assessment. Addendum The A nursing note, dated 3/20/11 at 7:00 corrective action for resident with p.m., indicated an open area was noted to pressure areas was having each pressure area noted on one page right buttock measuring 1 cm by 0.7 cm

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F187 05/25/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 E 21ST AVE SIMMONS LOVING CARE HEALTH FACILITY **GARY. IN46407** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE by 0 cm. The physician was informed and to track the progess or decline of the wound. The wound nurse an order to continue zinc oxide to monitors the wound monthly and buttocks was received.. The family was prn and the physician will monitor informed. the wound monthly and prn. The corrective action taken for residents having the potential for A nursing note, dated 3/22/11 at 8:00 pressure areas is as follows: p.m., indicated the resident was Braden Scale is done to positioned on her left side, "open area to r determine residents who are high (right) hip, pink edges no drainage or odor risk and pressure relieving devices are used. The wound is present." monitored and if the area worsens the resident is refered to A nursing note, dated 3//24/11 at 1:00 the wound clinic and plan of care a.m., indicated, "dark scab remains to r is determined and followed. The resident will continue to follow up (right) hip. with the wound clinic until wound is healed. The systemic measures A nursing note, dated 3/28/11 at 5:00 put into place are all residents had an updated Braden Scale a.m., indicated, "blister to right heel and Plan of Care completed. noted." At 3:45 p.m. the podiatrist was in Residents with high risk to see the resident. The resident's shoes of pressure sore developement is were to big. The family was made aware discussed during shift to shift and family was to bring in new shoes. report and tour check. The resident is monitored each shift for pressure relieving devices A physician order, dated 3/28/11, such as heel protectors, air indicated observe blister to right heel mattress, gel cushions and put to daily for negative changes. The blister bed to releive pressure, they are turned and repositioned every 2 appears to be resolving naturally. The hours and as needed. The resident was to acquire proper fitting resident is assessed each shoes. shift and if a pressure area is noted the physician is contacted to determine the course of A nursing note, dated 3/29/11 at 8:00 treatment. The Licensed Nurse p.m., indicated the open area to right will monitor skin sheets weekly buttock and right hip were healing and for residents with pressure without difficulty, there was epithelia areas the wound is monitored daily. The D.O.N. will monitor tissue present and no drainage or odor.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION 00	(X3) DATE S COMPL		
AND TEAN	or connection	15E187	A. BUILD B. WING	ING		05/25/2	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					1ST AVE		
	IS LOVING CARE H			GARY, II	N464U <i>1</i>		77.0
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	1	lated 3/30/11 at 3:45 ne physician was in to see			weekly wound sheets weekly monitor progress or regression pressure areas weekly ongoin until pressure area is resolve	on of ng	
	indicated, "fluid The physician was order was received heel, to rupt (rup dry gauze and serprotectors". A physician orde zinc oxide to right twice a day and a cover with dry gatape, and heel produced and the produced of t	lated 4/7/11 at 2:00 p.m., er to r (right) heel rd, dry, et (and) dark in					
	heel remains hard A nursing note, d	lated 4/12/11 at 5:00 ne open area to the right					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		NSTRUCTION 00	(X3) DATE S COMPL		
15E187			A. BUII B. WIN			05/25/2	
NAME OF I	PROVIDER OR SUPPLIER		D. ((1))		DDRESS, CITY, STATE, ZIP CODE		
					1ST AVE		
	IS LOVING CARE H			GARY, I	N46407		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	A nursing note, d	lated 4/13/11 at 5:00					
	a.m., indicated, "resident appears to be sleeping. Eyes open when name called.						
	Responds verbally." The resident was somewhat lethargic. At 5:15 a.m. during						
	1	resident was more					
		der was received to sent					
		tion and treatment.					
	Family notified.						
		er sheet dated 4/13/11,					
		m., "Resident appears to					
	1	pen eyes when name					
	I -	responsive. But very e (sic) getting more					
	ı ~	(sic) x (times) 5 days.					
		ost healed decubs (sic) to					
		and hip. Healing blister					
	to r (right) heel."	_					
	1	lated 4/14/11 at 2:16					
	l * '	ne resident returned to the					
	1 , , ,	t) heel with two ruptured y, hard and dark in					
	'	s measured 4.5 cm by 3.5					
		3.5 cm by 4 cm by 0 cm.					
	"Reopened bliste	•					
	1 ^	n by 1 cm by 0 cm." A					
		eceived to apply santyl (
) daily and cover with					
	1 -	arginaid (nutritional					
	**	box twice a day. At 7:00					
	l [*]	nurse was notified of the					
	areas.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15E187	B. WIN			05/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF			700 E 2	21ST AVE		
	IS LOVING CARE H	HEALTH FACILITY		GARY,	IN46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ГЕ	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE
	l						
	A nursing note, dated 4/15/11 at 2:00 p.m., indicated called the wound nurse in regards to the resident's wounds to her right heel and right hip and left message.						
]	1 . 1 . 1 . 1 . 1					
		dated 4/19/11 at 2:30					
	1 * '	he wound nurse changed					
		ls. The resident's family					
	was notified.						
	1 1	er dated 4/19/11, indicated					
	1 - 1 - 1	ure-un-stageble full					
	thickness area t	to be treated with santyl,					
	hydrogel and bot	rdered foam dressing					
	twice a day.						
	A nursing note, of	dated 4/23/11 at 7:34					
	p.m., indicated the	he right hip wound					
	measured 2.5 cm	by 2.0 cm by 0 cm and					
		nained dark with					
	hardened area to						
	A nursing note, of	dated 4/25/11, indicated					
	the resident was	turned and repositioned.					
		ed to the right hip wound					
		ount of serosanguinous					
		o dressing and pad in bed.					
	_	applied per orders and the					
	_	te to be monitor. At 7:30					
		continued to drain. An					
		ed to go to wound clinic					
		ole. At 2:00 p.m. upon					
	_						
	_	he resident was noted to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE SUR COMPLETE			
		15E187	B. WING		-	05/25/2011	
NAME OF T	DROWNER OF GURBLIEF		1		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			700 E 2	1ST AVE		
	IS LOVING CARE H			GARY, I	N46407		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	OMPLETION DATE
1710		a to her coccyx with a	+	mo			DATE
	1 *	bleeding noted. The area					
		y 1 cm by 0.2 cm. There					
		e physician was notified					
		received to start Keflex					
		ng (milligrams) one by					
	l ` ′	a day for 14 days and					
		nal supplement) mix with					
		n wound with normal					
	saline and cover	with duoderm (dressing)					
	every three days.	The family was					
	notified.						
	A nursing note, d	lated 4/26/11 at 6:00					
	a.m., indicated, '	'dressing change to r					
	(right) hip. Foul	smelling drainage noted.					
	Brownish in colo	or." The resident's right					
	heel remains darl	k and hard. At 8:00 a.m.					
		to go to the wound clinic					
		open areas to right hip,					
	•	occyx. The family was					
		0 p.m., the resident was					
	out to wound clir	nic, and staff					
	accompanied.						
	A Wound Clinic	note, dated 4/26/11,					
		dent had a temperature					
		The right hip wound					
	_	by 2.4 cm by 1.2 cm the					
		re was pale/gray, and					
	-	erate amount of purulent					
		or. The periwound					
		erythema (red) and the					
	necrosis was pres	sent. The right heel					

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AND PLAN	OF CORRECTION	15E187	A. BUI	LDING	00	COMPLETED 05/25/2011	
		130107	B. WIN			03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SIMMON	IS LOVING CARE H	IFALTH FACILITY			IN46407		
	_			<u> </u>	1110107		(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	wound measured	9.0 cm by 3.5 cm by 0.1					
		s necrotic with no					
	drainage. It was	dry gangrene. The					
	coccyx area measured 1.0 cm by 0.9 cm						
	by 0.1 cm. The	peri wound area was					
	intact. There wa	s no drainage or odor.					
	A hospital Histor	y and Physical, dated					
	4/26/11, indicate	d the resident was					
	transferred with	fever and dehydration.					
	The impression v	was Alzheimer disease,					
	history of past st	rokes, decubitus right					
	hip, sepsis, dehy	dration, and necrosis of					
	right heel. The p	lan: "The patient will be					
	started on IV (int	travenous) antibiotics.					
	1 -	bridement and possible					
	~	e Infectious Disease					
	consult with the	primary physician."					
	A care plan initia	ated on 3/17/11, indicated					
	_	oriation to right buttock,					
	1 -	ncluded, but were not					
	limited to, apply	air mattress to bed, keep					
	resident clean an	d dry at all times.,					
	provide care afte	r each incontinent					
	episode, and app	ly zinc oxide to buttock					
	1 ~	care plan was updated on					
	3/27/11 with exc	oriation resolved.					
	A care plan initia	ated on 3/17/11, indicated					
		b over healed old					
	1 *	t hip measuring 1 cm by					
	0.7 cm by 0 cm.	, ,					
	· ·	re not limited to, apply					

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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PERCEDED BY FILL REGILATORY OR LSC IDENTIFYING INFORMATION) air mattress to bed, avoid pressure to right hip, and apply zinc oxide as ordered. The care plan was updated on 3/27/11 with scab to right hip resolved. A care plan initiated on 3/28/11, indicated a problem of blister to right heel related to shoes being too large. The approaches included, but were not limited to, apply heel protectors, avoid pressure to heels, keep heels free floating, apply lower air mattress to bed, notify family for need of smaller size shoe, and podiatrist will follow up with resident to re-evaluation. A Weekly Wound Assessment Flow Record indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow Record indicated S1/7/11 the form indicated the area was healed. A Weekly Wound Assessment Flow Record indicated A S2/8/11, indicated a problem of blister to right heel related to shoes being too large. The approaches included, but were not limited to, apply heel protectors, avoid pressure to heels, keep heels free floating, apply lower air mattress to bed, notify family for need of smaller size shoe, and podiatrist will follow up with resident to re-evaluation.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
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SIMMONS LOVING CARE HEALTH FACILITY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL CARE DEPOSED TO THE APPROPRIATE SHORT OF THE APPROPRIATE SHORT OF THE APPROPRIATE SHORT OF THE APPROPRIATE OF COMPLETION DATE air mattress to bed, avoid pressure to right hip, and apply zinc oxide as ordered. The care plan was updated on 3/27/11 with scab to right hip resolved. A care plan initiated on 3/28/11, indicated a problem of blister to right heel related to shoes being too large. The approaches included, but were not limited to, apply heel protectors, avoid pressure to heels, keep heels free floating, apply lower air mattress to bed, notify family for need of smaller size shoe, and podiatrist will follow up with resident to re-evaluation. A Weekly Wound Assessment Flow Record indicated 3/17/11 wound identified with the box marked yes. The location was the right buttock, staged indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow			130107	B. WIN			03/23/2	011
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Record indicated 3/17/11 wound identified with the box marked yes. The location was the right buttock, staged indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		Tollow up with it	estactit to re-evaluation.					
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indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		identified with th	ne box marked yes. The					
the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		location was the	right buttock, staged					
an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		indicated excoria	tion. The tissue was red.					
relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		the treatment was	s zinc oxide and she had					
relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow		an air mattress ar	nd gel cushion as pressure					
indicated the area was healed. A Weekly Wound Assessment Flow		relieving devices	. On 3/27/11 the form					
		indicated the area	a was healed.					
		A Weekly Woung	l Assessment Flow					
Record indicated 3/17/11 the box was		1						
checked for yes that a wound was								
identified. The location indicated right		· ·						
buttock and the the stage was un-stageable			_					
(scab). There was no assessment noted			= =					
of the tissue color and no measurement		'						
was documented. There was no drainage								
or odor. The wound edges were in normal								

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
and Plan of Correction identification number: 15E187			A. BUII		00	05/25/2	
		100107	B. WIN		DDDEGG GITTY GTATE TIN GODE	00/20/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SIMMON	IS LOVING CARE H	IFALTH FACILITY			IN46407		
(X4) ID		TATEMENT OF DEFICIENCIES		ID I			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	limits and the sur	rrounding tissue was	İ				
	normal. The trea	atment was zinc oxide					
	and an air mattre	ss and gel cushion were					
	used for pressure relieving devices. On						
	3/27/11 the form indicated a check mark						
	by the wound ide	entified. The location					
	was right buttock	and the stage healing.					
	The tissue color	was cab off solid pink					
	tissue. The area	measured 2 cm by 4 cm					
	by 0 cm. There v	was no drainage or odor.					
	The wound edges	s were within normal					
	limits and the sur	rrounding tissue was					
	within normal lir	nits. the area was					
	improved. The t	reatment was was zinc					
	oxide and pressu	re relieving devices					
	included an air m	nattress and gel cushion.					
	On 3/28/11 there	was a check in the box					
	l ⁻	vound identified. It was					
	_	r and the tissue color was					
		e were no measurements					
		was no drainage and on					
		d edges were attached					
		ing tissue was normal.					
		heel protectors and an air					
		pressure relieving device					
		the box marked yes was					
		nd was identified. it was					
	· ·	the blister had ruptured.					
		ng assessed for tissue					
		ments. There was a					
		drainage that was serous					
	_	es were attached and the					
		ne was within normal					
	limits. The treati	ment was zinc oxide,					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15E187	B. WING		05/25/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
SIMMON	IS LOVING CARE H	IΕΔΙΤΉ ΕΔΟΙΙΙΤΥ		21ST AVE IN46407	
				1	(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
	dressing and tape	e and heel protectors.			
		eving devices were low			
	air mattress and l	-			
		•			
	There were no ot	her Weekly Wound			
	Assessment Flow	Record for the right hip			
	in the resident's o	chart or in the skin			
	treatment book u	ntil 4/14/11 and no other			
	flow records for	the resident's right heel.			
	A Weekly Wound	d Assessment Flow			
	Record dated 4/1	4/11 indicated a check			
	_	box that a wound was			
		right hip the tissue color			
		the area measured 1 cm			
	1	termined. There was a			
		serosanguinous drainage			
	l `	and blood) with no odor.			
	the edges were at				
	~	ne was normal. On			
	· · · · · · · · · · · · · · · · · · ·	hip measured 1 cm by 1			
	l ř	ned. The tissue was			
	1 2	sanguinous drainage and			
		atment was changed to			
	1	hydrogel and foam			
	_	day. On 4/25/11 the right			
		and measured 2.5 by 2			
	I -	ned. There was a small			
	had an odor and	inguinous drainage that			
		n 4/25/11 a wound had			
		the coccyx area that was			
	_	rea was beefy red			
	measuring i cm	by 1 cm by 0.2 cm. there			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
15E187		LDING	00	05/25/2			
		102107	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2	
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
SIMMON	IS LOVING CARE I	HEALTH FACILITY		1	IN46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		ount of serous (serum)					
	drainage with no odor.						
	A Weekly Wound Assessment Flow						
	1	20/11, indicated a check					
	1	e box yes for wound					
	1 ^	at buttock at a Stage II.					
	_	ed and the area measured					
		by 0 cm. there was no					
	1 -	The edges were					
	1 -	surrounding tissue was					
	1	atment was continue zinc					
		essure relieving devices					
	1	s and gel cushion. On					
	1	buttock area was a Stage					
	1	neasuring 1 cm by 0.7 cm					
	1	drainage or odor. The					
	1 -	ere attached and the					
	1	ue was normal. The					
	1	essure relieving devices					
	1	On 4/3/11 the Right					
	1	age II red in color					
	1	by 0.7 cm by O cm.					
		ainage no odor, the					
		ere attached and the					
		ue was normal. The					
	1	essure relieving devices					
	1	d. On 4/10/11 the right					
	1	age I measuring 0.7 cm					
	1	em. the tissue had					
	1 '	with no drainage or odor.					
	The edges were	_					
		ue was normal. There					
		n the treatment or the					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	ETED
		15E187	B. WING	10		05/25/2	011
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		7	00 E 2	1ST AVE		
	IS LOVING CARE H				N46407		
(X4) ID		TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	1	EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	17	AU			DATE
	pressure relieving	g devices.					
	Th	1 337 1 1 337 1					
	There were no other Weekly Wound Assessment Flow Records for the right						
		v Records for the right					
	buttock.						
	A Washir Clair A	aggaggment forms in directed					
	1	Assessment form indicated					
		was an open area to the					
	~	asuring 0.7 cm by 0.3 cm					
	*	4/11 there was an open					
		1 cm by 1 cm by 0 cm.					
		ruptured blister to the					
	~	ring 4.5 cm by 3.5 cm by					
		by 4 cm by 0 cm. On					
		s an open area to the right					
		n by 0 cm and two					
	ruptured blisters						
		n by 3.5 cm x 0 cm and					
	3.5 cm by 4 cm t	oy 0 cm.					
	The Weekly Pres	sure Area, Blister or Skin					
	1	nt Schedule Policy was					
		Director of Nursing on					
	^	.m. The purpose: "To					
		nt's skin condition heals					
		vel as possible with skin					
	1 ^	•					
	becoming intact.						
	Procedure:	1 C1.!! -					
		Braden Scale" assessment					
		on, reassess quarterly					
		oon significant change. 2.					
	If resident is ider						
		integrity provide					
	precautions/inter	ventions to decrease the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		A. E) MULTIPLE CO BUILDING VING	NSTRUCTION 00	Î	3) DATE SURV COMPLETED 05/25/2011		
	PROVIDER OR SUPPLIER		р. V	STREET A	DDRESS, CITY, STA 1ST AVE N46407	TE, ZIP CODE		
								(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) MPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFI	CIENCY)		DATE
	risk of pressure a	areas, blister, or skin tear.						
	3. Document spe	ecific problems,						
	interventions and	d goals on resident's care						
	plan. 4. Review	and update the care plan						
	with scheduled re	evisions of resident's						
	condition change	es. 5. If pressure area,						
	·	ar occurs, assess and						
		eekly wound assessment:						
	A. Location. B.	Stage etc. C. Size (cm)						
	length x (times)	width. D. Wound depth						
	(cm). E. Odor. l	*						
	` ′	ressure area or facility						
	_	ysician notified and						
	^ *	I. Family notification.						
		and areas with eschar						
	"	erred to the Wound Nurse						
	or Wound Clinic							
		ill be recorded on the						
		ssessment sheet. 3.						
	Pressure Area Lo							
		hly and given to the						
	1 ^	ng for Quality Assurance						
	Meeting."	ing for Quarity Assurance						
	iviceting.							
	On 5/25/11 at 1:0	00 p.m., the Director of						
		vas interviewed she						
		e above Weekly Wound						
		v Record that included						
		and the right heel should						
	_	ed right buttock but right						
		indicated there must be a						
	1 ^	Wound Assessments						
	· ·	ssing for the right hip and						
		is time the DoN indicated						
FORM CMS-2	2567(02-99) Previous Version		KF0Z	11 Facility I	D: 000368	If continuation sheet	t Page 3	l 7 of 43

PRINTED: 06/23/2011 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	 15F187		LDING	00	COMPLETED 05/25/2011	
		15E167	B. WIN			05/25/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SIMMON	S LOVING CARE H	IEALTH EACH ITY		1	1ST AVE IN46407		
					11140407		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
IAG			+	IAG			DATE
		en two areas to the right					
	buttock: the 3/17/11 area that healed on 3/27/11, and the open area that was found on the right buttocks on 3/20/11. She further indicated she would look into						
	'	y Wound Assessment					
		ere and provide the					
	forms.						
	On 5/25/11 at 2:0	00 p.m. the Weekly					
		2					
	Wound Assessment Flow Records were requested again from the DoN. The DoN						
	-						
		ew the missing Weekly					
		ent Flow Records had not					
	been provided an	nd would provide them.					
	On 5/25/11 at 3:1	15 p.m., the DoN was					
		e indicated that when the					
	resident returned	to the facility on 4/14/11					
		-					
	•						
		ke membrane where the					
		cated. "It was like there					
		nder the thin membrane."					
	_						
	_						
		•					
		_					
		•					
		_					
	_						
	_						
		-					
		_					
	resident returned the resident's hip the scab was no laws a thin film liscab had been low was something us. We were not goin but the treatment hopes of opening was in on 4/19/1 dressing again the wound change received to go to soonest we could day. At 3:45 p.m.	to the facility on 4/14/11 wound was spongy and longer present and there ke membrane where the cated. "It was like there					

000368

l '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED 05/25/2011		
102.107			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					1ST AVE		
SIMMON	IS LOVING CARE H	IEALTH FACILITY		GARY, I			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
IAG		he QA (quality assurance	+	IAG			DATE
		N indicated these forms					
	1 * * /	vound measurement that					
		ed earlier in the day. She					
	_	ould be part of the					
		because they were copies					
		ound Assessment Flow					
	l -	pies were provided. The					
	_	ted that the Weekly					
		ent Flow Records were					
	different from the forms previously provided because she told staff that all information on one skin area was to be on one form. She did not want different wound areas on the same form. There was additional data provided on these forms that was not on the original forms						
		ovided. At this time she					
	also indicated the physician had seen the resident's wounds on 3/30/11 but had not						
	been back in to the	he facility due to personal					
	reasons, but the facility had the wound						
	nurse come in and see the resident.						
	This federal tag relates to Complaints IN00090539 and IN00090585.						
	3.1-40(a)(2)						

PRINTED: 06/23/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		A. BUILI	DING	00	COMPL 05/25/2	ETED		
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			B. WING GS/23/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN46407					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F0323 SS=G	environment remandazards as is possoreceives adequated devices to prevent Based on record facility failed to a to fall risk for a rewho was a double practice affected related to falls in #E) Resident #E treatment in the experiment in the experime	review and interview, the assess or plan care related newly admitted resident e amputee. The deficient 1 of 1 resident reviewed a sample of 6. (Resident sustained a fall requiring emergency room,	F03	23	F Tag 323 Free Of Accident Hazards/Supervision/Device What corrective action will be accomplished for those reside found to have been affected the deficient practice? Resinguiant and the terminant of the termin	dents by dent leted ssion al to ccient dent dent dent dent dent dent dent d	06/24/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KF0Z11

Facility ID:

000368 If continuation sheet

Page 40 of 43

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN	JC.	00	COMPLETED	
		15E187	B. WING	NO		05/25/2011	
				TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ST AVE		
SIMMON	IS LOVING CARE H	IEALTH FACILITY		BARY, IN			
							
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF THE APPROPRIATE OF T	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Tz	AG	DEFICIENCY)		DATE
	amputation, and	right below the knee			does not recur. In Service of		
	amputation.			documentation for residents Fall			
					Assessments on accuracy and completion was done 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. designee will monitor all admission nurse admission		
	Review of the A	dmission Assessment for					
	 dated 4/4/11 at 4	:00 p.m. indicated the					
		of Falls" was not					
	· ·						
	1 1	re were no boxes checked					
		areas: "if checked,			records and fall risk assessm		
	further evaluation required per facility policy", "no history of falls", "fell in past				upon admission and quarterl	-	
					risk assessments. Director of		
	30 days", and "fell in past 31-180 days".				Nursing and or designee will and monitor monthly and	audit	
	A nursing note dated 4/30/11 at 6:49 a.m., indicated resident completed dinner and propelled self via wheelchair to room				determine future in-service		
					training needs. The D.O.N. v	will	
					discuss progress How the		
					corrective action will be moni	itored	
	1 ^ ^				to ensure the deficient practi-		
		The resident was found			will not recur. The D.O.N. w		
	· ·	or, crying. Staff assessed			discuss progress and concer		
	the resident for b	ruising and bleeding was			the and concerns to the Q.A.		
	noted to right for	efinger.			Committee and the committee determine effectiveness of the	-	
					assessment policy and	ic iaii	
	A nursing note da	ated 4/30/11 at 7:14 p.m.,			procedures. We are working	ıa on	
	_	dent was transported to			updating the computer syste		
		dent was transported to			include all assessments with	the	
	the hospital. A nursing note dated 4/30/11 at 11:56				MDS program once the basic		
					problems with the new 3.0 M	DS	
					system are corrected. 5.		
p.m., indicated resident returned to the facility with new orders for Bactrim DS				Completion Date: 6/24/2011 AddendumThe			
				corrective action taken for			
	(antibiotic) one, by mouth, twice a day for seven days and Hydralazine (used to treat high blood pressure, hypertension) 100				resident E was a fall assessr	nent	
					was completed and a lap but		
					applied when up in wheelcha		
mg (milligrams) one, by mouth, three times a day. The resident received four				prevent her from leaning to fa	ar		
					foward. No other falls have		
	· ·				occured with Resident EThe		
		eration on her right			corrective action taken for		
forefinger			I	l	residents having the potentia	II (O	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
I		IDENTIFICATION NUMBER:		LDING	00	COMPL	
15E187		B. WIN	IG		05/25/2	011	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE	-	
					1ST AVE		
SIMMON	IS LOVING CARE H	HEALTH FACILITY		GARY, I	IN46407		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	Interview with S Director/Human 5/25/11 at 8:25 at the Resident Nurneed to be compiblank. Interview with La.m., indicated a Nursing Assessment to the facility. Note that I have been to the facility of the Resident #E's assessment form not have been, he been another fall The facility had and the assessment computer. At the exit conference was no fall the resident when facility.	Resource Manager on a.m., indicated all area of rising Assessment form leted. No area should be LPN #1 on 5/25/11 at 8:35 Ill areas of the Resident ment form were to be a resident was admitted to area should be blank. The Director of Nursing on a.m., indicated the area on a resident nursing was blank and it should assessment completed. The computer programs are computer programs and computer programs are completed on a serious of Nursing indicated assessment completed on a she was admitted to the relates to Complaints		IAU	be affected by falls is as followed particles. The systemic measure and into place are all resident are a high fall risk are monitored through each shift or anti-falling devices are medically and are a high fall risk are monitored through each shift 24 hours per day. Shift is monitored by the channurse and any falls or incider are reported to the D.O.N. immediately. The D.O.N. will monitor the fall risk assessm and anti-fall devices weekly to the months to ensure ongoing compliance.	ed nsor, ures twho ored ces. to Fhe nout Each rge nts I ents imes	DATE
	3.1-45(a)(2)						

000368

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E187		A. BUILDING B. WING	00	COME	COMPLETED 05/25/2011				
NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN46407						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE			